STATEMENT OF THE

AMERICAN DENTAL ASSOCIATION
TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON ENERGY AND COMMERCE
U.S. HOUSE OF REPRESENTATIVES

ON

INSURING BRIGHT FUTURES: IMPROVING ACCESS TO DENTAL CARE AND PROVIDING A HEALTHY START FOR CHILDREN

SUBMITTED BY

KATHLEEN ROTH, D.D.S.
PRESIDENT

MARCH 27, 2007

My name is Kathleen Roth, president of the American Dental Association (ADA). I am a practicing dentist in West Bend, Wisconsin, and a Medicaid provider. I also participate in Wisconsin's State Children's Health Insurance Program (SCHIP). Chairman Pallone and members of the subcommittee, the ADA, which represents over 72 percent of the dental profession, thanks you for holding this hearing and calling attention to the need for improving access to oral health care for America's children. As you are well aware, the nation was shocked by the recent death of 12 year old Deamonte Driver—who lived only a short drive from here—from a brain infection apparently related to untreated dental disease. On behalf of the American Dental Association I extend my heartfelt condolences to the family of Deamonte. Clearly, the oral health care system failed this young man. All of us – practitioners, payers, parents and policymakers – need to come together and make the system work for the most vulnerable among us.

The impact of poor oral health can, as this tragic case shows, go far beyond the mouth. It is well documented that poor oral health can lead to oral infections that can affect systemic health, and new evidence is emerging all the time. Oral bacteria have also been associated with bacterial pneumonia in bed or chair-bound patients, and might also be passed from mother to child resulting in a higher prevalence of caries in these children. Although it's not clear if treating an oral disease will improve specific health problems, we do know that oral health is important for overall health and vice versa.

Deamonte Driver's inability to obtain timely oral health care treatment underscores the significant chronic deficiencies in our country's dental Medicaid program. Fundamental changes

to that program are long overdue, not simply to minimize the possibility of future tragedies, but to ensure that all low-income children have the same access to oral health care services enjoyed by the majority of Americans.

Disparities in Access to Oral Health Services

As U.S. Surgeon General David Satcher noted in his 2000 landmark report *Oral Health in America*, [1]dental caries (tooth decay) is the most common chronic disease of childhood – five times as common as asthma, and low-income children suffer twice as much from dental caries as children who are more affluent. According to the report, about 80 percent of the tooth decay occurs in only about 25 percent of the children – children who are overrepresented in the lower socioeconomic strata. According to the Centers for Disease Control and Prevention (CDC), [2]our society as a whole has made real progress toward reducing the morbidity of oral disease; however, existing disparities among specific populations persist. For example, children from non-Hispanic black and Mexican-American populations and families below 200 percent of poverty have a greater amount of tooth decay that non-Hispanic whites and families above the 200 percent of poverty level.

Barriers to Accessing Oral Health Care Services

There are many barriers to providing every child from a low-income family in America with good oral health care services. Some of the barriers make it difficult to supply care (such as the geographic distribution of providers), some affect the demand for services (such as a caregiver's

[1] Department of Health and Human Services (US). Surgeon General's report on oral health, 2000. Available from: URL: http://www.surgeongeneral.gov/library/oralhealth/

[2] Beltran-Aguilar ED, Barker ZK, Canto MT, et al. Surveillance for dental caries, dental sealants, tooth retention, edentulism, and enamel fluorosis: United States, 1988-1994 and 1999-2002. MMWR Surveill Summ 2005;54(3):1-44.

lack of appreciation of the importance of oral health), but all of them impact the ability of the underserved children to access dental services.

Supply Side Activities

On the supply side, the ADA promotes oral health through community-based initiatives, including water fluoridation, sealants and use of topical fluoride in public health programs and dental offices.

We also recognize adjustments in the dental workforce are necessary to more effectively address the special needs of underserved communities, especially children, and have endorsed the development of a new member of the dental team – the Community Dental Health Coordinator (CDHC) – to help address those needs. The CDHC will be a new mid-level allied dental provider who will enable the existing dental workforce to expand its reach deep into underserved communities and can be employed by Health Centers, the Indian Health Service, public health clinics, or private practices. CDHCs will be competent in developing and implementing community-based oral health prevention and promotion programs; providing individual preventive services (such as fluoride and sealant applications); and performing temporization on dental cavities with materials designed to stop the cavity from getting larger until a dentist can see the patient.

Congress must continue to fund crucial federal oral health care access programs. The ADA and the larger dental community have for years worked to ensure there was adequate funding for key oral health access programs within the Department of Health and Human Services (HHS) that

provide dental research and education, as well as oral health prevention and community-based access programs. Each of these programs is important as a means of helping to ensure access to oral health care, especially for the disadvantaged children in our society.

Each year, the ADA and other national dental organizations work to ensure adequate support for the Health Resources and Services Administration's Health Professions Education and Training Programs[3]; HRSA's Maternal and Child Health Bureau (MCHB)[4]; the Centers for Disease Control and Prevention's Division of Oral Health[5]; the National Institute of Dental and Craniofacial Research (NIDCR)[6]; the Ryan White HIV/AIDS Dental Reimbursement Program (Part F, Ryan White CARE Act) [7] ; and most significantly, the Title VII general, pediatric and public health dentistry residency programs within HRSA.[8] We call upon Congress to properly support these vital programs as part of our collective effort to fix the access problems for children from low-income families and other underserved.

[3] Health professions education and training programs have a critical role in the recruitment and retention of minority and disadvantaged students and faculty. These programs are crucial if we are to address concerns with health disparities.

[4] Specifically, oral health projects in the Health Resources and Services Administration, Maternal and Child Health Bureau (MCHB), Title V, Special Projects of Regional and National Significance (SPRANS) account.

[5] The Centers for Disease Control and Prevention's Division of Oral Health (DOH) supports state- and community-based programs to prevent oral disease, promote oral health nationwide and foster applied research to enhance oral disease prevention in community settings. The CDC works with states to establish public health research that provides valuable health information to assess the effectiveness of programs and target populations at greatest risk. In addition, through the DOH, states can receive funds to support prevention programs that aim to prevent tooth decay in high-risk groups, particularly poor children, and reduce oral health disparities.

[6] NIDCR is the only Institute within the NIH that is committed to oral health research and training. Institute-sponsored research continues to link oral infection to such systemic diseases as diabetes, cardiovascular disease (heart attack and stroke) and adverse pregnancy outcomes (preterm birth and low birth weight). The Institute remains the primary public agency that supports dental behavioral, biomedical, clinical, and translational research.

[7] The Ryan White HIV/AIDS Dental Reimbursement Program increases access to oral health services for people living with HIV/AIDS; ensures that dental and dental hygiene students and dental residents receive the most current training; and assist in defraying the rising non-reimbursed costs associated with providing such care by dental education institutions.

[8] Title VII dental residency programs are instrumental in training dentists who work in underserved communities and treat Medicaid, SCHIP or other underserved populations, particularly those with special needs.

The ADA is also very pleased that the House companion bill to S. 739, the "Children's Dental Health Improvement Act 2007," that will be cosponsored by Representatives Dingell and Simpson, will soon be introduced. That legislation will do a great deal to improve delivery of dental care in Medicaid and SCHIP and ensure a chief dental officer presence in key federal agencies, among many other initiatives.

The ADA has long supported incentives at the federal level to encourage private sector dentists to establish practices in underserved areas, such as a tax credit to establish an office in an underserved area. We also work with and support our colleagues who practice in Health Centers, which are provided section 330 funding in exchange for providing care to all regardless of ability to pay. We have an excellent working relationship with the National Association of Community Health Centers (NACHC) and encourage our private sector members to work cooperatively with the centers in their communities. We support an arrangement that facilitates the ability of private sector dentists to contract with Health Centers, thereby providing the centers with another option to efficiently provide dental services to Health Center patients when and where those services are needed. In addition, the ADA was the founding member of the Friends of the Indian Health Service and has for many years actively lobbied to increase funding for the IHS's dental program, including full funding for IHS loan repayments.

And dentists understand their ethical and professional responsibilities too. In the absence of effective public health financing programs, many state dental societies joined with other community partners to sponsor voluntary programs to deliver free or discounted oral health care to underserved children. According to the *ADA's 2000 Survey of Current Issues in Dentistry*,

74.3 percent of private practice dentists provided services free of charge or at a reduced rate to one or more groups (e.g., homebound, handicapped, low income). A total national estimate of the value of this care was $1.25 billion, or $8,234 per dentist. In 2003, the ADA launched an annual, national program called "Give Kids A Smile" (GKAS). The program reaches out to underserved communities, providing a day of free oral health care services. GKAS helps educate the public and state and local policymakers about the importance of oral health care while providing needed and overdue care to large numbers of underserved children. The ADA's fifth annual Give Kids A Smile event on Feb. 2, 2007, was again highly successful. More than 53,900 dental team members registered to participate on ADA.org, including 14,220 dentists. Nationwide, 2,234 programs were held. Registered participants treated some 755,600 children, and valued the care at $72,276,000 ($95 on average per child). Of course, poor children shouldn't have to depend on charity for basic dental care. These efforts are important but are no substitute for fixing the Medicaid program.

Demand Side Activities

University researchers seeking to identify the barriers to oral health care faced by low-income caregivers concluded that efforts need to be made to educate caregivers about the importance of oral health for overall health. [9] The ADA and other professional dental organizations agree that early intervention is very important in assuring that a child has good oral health. Accordingly, the ADA recommends that children see a dentist for the first time within 6 months of the

[9] S.E. Kelly; C.J. Binkley; W.P. Neace; B.S. Gale, "Barriers to Care-Seeking for Children's Oral Health Among Low-Income Caregivers," *American Journal of Public Health*, Aug 2005; 95, 8; Alumni – Research Library, pg. 1345.

appearance of the first tooth and no later than the child's first birthday.[10] The American Academy of Pediatric Dentistry also recommends that all children should visit a dentist in their first year of life and every 6 months thereafter, or as indicated by the individual child's risk status or susceptibility to disease.[11] The ADA also has a number of initiatives it is undertaking to address oral health literacy issues. They include: implementing an advocacy strategy to increase the number of school districts requiring oral health education for K-12 students; encouraging the development of oral health literacy continuing education programs to train dentists and allied dental team members to communicate effectively with patients with limited literacy skills; and developing guidelines for the creation of educational products to meet the needs of patients with limited literacy skills, including the involvement of targeted audiences in materials development.

Challenges Associated with the Medicaid Program

To truly address the oral health access problems faced by underserved populations, we need to get more private sector dentists participating in Medicaid. Over 90 percent of all practicing dentists are in the private sector (totaling over 162,000). Safety net facilities that target underserved populations are, of course, very important but they employ relatively few dentists. Efforts to expand care *only* through safety net facilities will not fix the access problem. For example, in fiscal year 2005, Health Centers receiving section 330 funding employed about 1,738 (FTE) dentists.[12] Even after significant growth in Health Centers in the past several years,

[10] American Dental Association, ADA statement on early childhood caries, 2000. Available from: www.ada.org/prof/resources/positions/statements/caries.asp.
[11] American Academy of Pediatric Dentistry, Guideline on periodicity of examination, preventive dental services, anticipatory guidance, and oral treatment for children. Available from: www.aapd.org/media/Policies_Guidelines/G_Periodicity.pdf.
[12] DHHS, HRSA, BPHC, 2005 Uniform Data System.

that is still less than one percent of the total of 177,686 active dentists in the United States in 2005.[13]

Seventy-five percent of Medicaid enrollees are children and their parents and about half of the program's 60 million 2006 enrollees are poor children, making it the federal government's largest health care program in terms of enrollment. [14] At the same time, according to the Congressional Budget Office (CBO), many eligible people do not enroll in the program and there have been estimates that about 33 percent of the 10 million children identified as uninsured are eligible for Medicaid. [15] So, experts estimate that over 30 million American children meet Medicaid eligibility requirements.

There are a number of factors that work against bringing more private sector dentists into the Medicaid program – but they can be overcome if we all work together. As CBO points out, analyses of Medicaid's reimbursement rates have found them to be lower than Medicare or private insurance rates.[16] This was also discussed in a General Accounting Office study, which also recognized a number of administrative barriers. [17] In short, the vast majority of the dental Medicaid programs in the United States are woefully under funded and the reimbursement rates simply cannot attract enough dentists. Where these programs have been enhanced, the evidence is clear that dentist participation increases. In addition, high student debt pressures young dentists to go into the private sector and makes it fiscally less feasible to take public health or

[13] American Dental Association, Survey Center.
[14] Congressional Budget Office, Medicaid Spending Growth and Options for Controlling Costs, Statement before the Special Committee on Aging, July 13, 2006, pp. 1-3.
[15] T.M. Selden, J.L. Hudson, and J.S. Ban thin, "Tracking Changes in Eligibility and Coverage Among Children, 1996-2002," *Health Affairs*, vol. 23, no. 5 (September-October 2004), pp. 39-50.
[16] CBO, Ibid. at p. 4.
[17] General Accounting Office, "Oral Health … Factors Contributing to Low Use of Dental Services by Low-Income Populations," September 2000. p.4.

clinic positions. Significantly, the American Dental Education Association reported that indebtedness for dental school graduates averaged $118,720 in 2003, with public school graduates averaging $105,350 and private/State-related school graduates averaging $152,525. This level of debt puts a great deal of pressure on young dentists to set up private practices in relatively affluent areas to the exclusion of underserved areas.

Potential Solutions

In 2001, the Urban Institute wrote an early assessment of the State Children's Health Insurance Program (SCHIP) [18]and concluded that "….different delivery systems supported by competitive payments appears to be contributing to improved provider participation and better access to dental care in some state SCHIP programs." [19] Most important, the study noted what it called a "spillover" effect on the Medicaid programs in two states – Alabama and Michigan. [20] The authors stated that the Alabama and Michigan officials reported that the early success of their dental SCHIP programs had expedited reform of their dental Medicaid programs and that data suggested that improvements in access may be occurring under Medicaid programs that are paying dentists at market rates. [21]

In October 2004, the ADA identified five state and community models for improving access to dental care of the underserved.[22] The Michigan and Alabama programs mentioned above are included among them, with Tennessee's TennCare program the other state level Medicaid model

[18] The Urban Institute, "Does SCHIP Spell Better Dental Care Access for Children? An Early Look at New Inititiatives," July 2001.
[19] Ibid, p. ix.
[20] Ibid.
[21] Ibid.
[22] American Dental Association, "State and Community Models for Improving Access to Dental Care for the Underserved," Executive Summary, October 2004.

program cited. The report also identifies two community level initiatives that show great promise of enhancing access to Medicaid eligible children. The Association chose these five based on suggestions from state policymakers and other public and private sector stakeholders.

A very recent study of the first five years of Michigan's "Healthy Kids Dental" Medicaid program[23] concludes that an increasing proportion of children received dental care each year from local providers close to home; the number of dentists continues to increase; and many of the children in the program appear to have a dental home and are entering regular recall patterns. Meanwhile, the Michigan Department of Community Health expanded the program to 59 of Michigan's 83 counties, effective May 1, 2006.[24]

Concerning the TennCare dental program, between October 2002 and October 2006, the number of dentists participating statewide grew by 112 percent and in rural counties by 118 percent.[25] This growth occurred after the dental program was "carved out" of the Medicaid medical program in 2002, whereby the dental care was administered by its own benefits manager and had its own funding stream, comprising 2 percent of the entire TennCare budget. The carve out facilitated the development of a good working relationship with the Tennessee Dental Association and other stakeholders, resulting in a streamlined dental administrative process, among other improvements. Four other states use a similar dental carve out system – California, Illinois, Massachusetts (in progress), and Virginia. Finally, the Alabama program (Smile Alabama!) has also significantly improved dentist participation. State officials note the increase

[23] S.A. Eklund, "Michigan's Medicaid "Healthy Kids Dental" Program: Assessment of the First Five Years," University of Michigan School of Public Health.
[24] Ibid.
[25] J. Gillcrist, "TennCare Dental Program: Before and After the Carve Out"

in reimbursement rates and its outreach to dentists as significant contributing factors in growing that program. [26]

To be clear, the Association is not suggesting that the programs identified in ADA's state and community models document are the only ways to begin to address the oral health access problems facing low-income children – or even the best ways in all cases. We are simply suggesting that while the problems are considerable, they are not insurmountable if all parties work together. We believe there is a great deal that Congress can do to encourage other states to take similar measures to improve their dental Medicaid programs through grants and other means.

Conclusion

All of us – practitioners, payers, parents and policymakers – need to come together and make the system work for the most vulnerable among us. Fundamental changes to the Medicaid program are long overdue to ensure that low-income children have the same access to oral health care services enjoyed by the majority of Americans. While we have made progress toward reducing the morbidity of oral disease, significant and persistent disparities continue to adversely affect underserved populations.

Dentists understand their ethical and professional responsibilities and have tried to address the access dilemma in a variety of ways. The ADA promotes oral health through community-based initiatives, such as water fluoridation, sealants and use of topical fluoride in public health programs and dental offices. We endorse adjustments in the dental workforce, including the

[26] Smile Alabama! "Alabama Medicaid's Dental Outreach Initiative."

development of Community Dental Health Coordinators, who could greatly enhanced the productivity of our dental teams in the future and will bring the expertise needed to efficiently address the oral health care needs of many in underserved populations, especially children in low-income families. For many years, the Association has lobbied Congress to adequately fund oral health care access programs, such as the Health Resources and Services Administration's Health Professions Education and Training Programs, which is crucial in addressing concerns with health disparities. We support an arrangement that facilitates the ability of private sector dentists to contract with Health Centers and many state dental societies cosponsor voluntary programs to deliver free or discounted oral health care to underserved children. Of course, all of the above efforts are no substitute for fixing the Medicaid program.

To truly address the oral health access problems faced by underserved populations, we need to get more private sector dentists participating in Medicaid. Over 90 percent of practitioners are in the private sector, and with over 30 million children estimated to be Medicaid eligible, there is simply no other way to adequately serve such a large segment of our nation. We have cited examples of several states that have made great strides in fixing their Medicaid programs, such as the "Healthy Kids Dental" in Michigan, "TennCare" in Tennessee and "Smile Alabama!" in Alabama. There are certainly many more examples, especially at the community level, that have also been effective. We believe there is a great deal that Congress can do to encourage other states to take similar measures to improve their dental Medicaid programs through grants and other means.

The problems are numerous and complex, but they are not insurmountable if we have the will to take the necessary steps to fix this problem. For too long, dental disease has been the "silent epidemic." The tragic fate of young Deamonte Driver—and the many others who have died from untreated dental disease—show the gravity of untreated dental disease.

Mr. Chairman, our nation's most vulnerable citizens deserve better care than we have provided. The ADA stands ready to do its part, and we call upon our many friends in Congress to work with us to ensure that every child can face his or her future with a smile.

American Dental Association
www.ada.org

American Dental Association

STATE AND COMMUNITY MODELS FOR IMPROVING ACCESS TO DENTAL CARE FOR THE UNDERSERVED

October 2004

Executive Summary

American Dental Association. *State and Community Models for Improving Access to Dental Care For the Underserved—A White Paper.* Chicago: American Dental Association: October 2004.

To obtain a complete copy of *State and Community Models for Improving Access to Dental Care for the Underserved—A White Paper,* go to www.ada.org or e-mail access@ada.org.

VISION STATEMENT

With each passing year, science uncovers more evidence of the critical importance of oral health to overall health. Early diagnosis, preventive treatments and early intervention can prevent or halt the progress of most oral diseases-conditions that, when left untreated, can have painful, disfiguring and lasting negative health consequences. Yet millions of American children and adults lack regular access to routine dental care, and many of them suffer needlessly with disease that inevitably results. Oral health access problems cut across economic, geographic and ethnographic lines. Racial and ethnic minorities, people with disabilities, and those from low-income families are especially hard hit.

The nation's dentists have long sought to stem and turn the tide of untreated disease, as individuals, through their local, state and national dental societies, and through other community organizations. Dentists alone cannot bring about the profound change needed to correct the gross disparities in access to oral health care. But dentistry must provide the leadership that initiates change, or it will not occur.

Ultimately, education and prevention will be the linchpins in eliminating, or at least minimizing, untreated dental disease. The day that we as a nation decide to provide oral health education to families of newborns, public health measures such as community water fluoridation, and regular dental visits to every American will mark the birth of the first generation that could grow up essentially free of dental disease. Until that occurs, the nation will be challenged to meet the needs for preventive and restorative care among large numbers of Americans who do not have dental coverage, cannot afford care or face other challenges that prohibit them from seeking regular oral care and dental visits.

The American Dental Association and its members will continue working with policymakers to establish programs and services that improve access to oral health care. We urge the nation to join us in:

- Rejecting programs and policies that marginalize oral health, and instead supporting those that recognize that oral health is integral to overall health and can affect a person's self esteem, ability to learn and employability.
- Acknowledging that the degree of oral health disparities and the extent and severity of untreated dental disease-especially among underserved children-is unacceptable.
- Committing, through both advocacy and direct action, to identify and implement commonsense, market-based solutions that capitalize on the inherent strengths of the American dental care system and that make it possible for all Americans, regardless of their financial, geographic, physical or other special circumstances, to experience optimal oral health care.

EXECUTIVE SUMMARY

BACKGROUND: Oral health means much more than healthy teeth and gums. It is integral to overall health, self-esteem, ability to learn and employability. The 2004 white paper State and Community Models for Improving Access to Dental Care for the Underserved is the latest in a series of ADA publications, programs, symposia and other initiatives aimed at state and federal policymakers, the public health community, the media, other opinion leaders, the dental profession and the general public about the extent of unmet need for dental care among large groups of Americans. The poor—including low-income elderly—the disabled and residents of those rural and inner city areas where attracting a dentist is difficult, are particularly hard hit.

Dentists provide billions of dollars in charitable education, screening, preventive and restorative services, both as individuals and through their local, state and national professional societies. But charity care alone—even of this scope—is not a long-term solution to making oral health care accessible to the millions of Americans who do not get it.

BARRIERS TO CARE: Federal law requires states to cover dental benefits for Medicaid eligible children. All states except Texas and Delaware also provide dental services to children eligible for the State Children's Health Insurance Program. But with a few exceptions, these programs—typically underfunded and poorly administered—provide dental services to only a small percentage of those eligible. Access to dental care for low-income and disabled adults is exponentially worse, with few public assistance programs providing adequate coverage.

- Medicaid reimbursement rates are often so anemic, and administrative burdens so onerous, as to discourage provider participation. In many cases, reimbursement rates fail to cover even dentists' overhead costs in providing care.
- Even when care is available, programs often fail to provide the case management services needed to help people get to dental appointments and comply with post-treatment instructions and oral hygiene protocols.
- Low levels of oral health literacy lead to often-severe dental disease that could otherwise be prevented cheaply and easily.
- Economic conditions discourage dentists from practicing in some inner city and rural areas, creating location-specific dentist shortages.

MARKET-BASED SOLUTIONS: Working with other stakeholders, the ADA has researched extensively the problems plaguing dental public assistance programs and the innovations under way in some states and localities to address them. This paper examines five models, three at the state level and two at the community level, which other states and communities could adopt, modifying them as appropriate to meet the specific needs of their residents.

1) Michigan's Healthy Kids Dental Medicaid demonstration program is a partnership between a state Medicaid program and a commercial dental plan, with the plan managing the dental benefit according to the same standard procedures and payment mechanisms it uses in its private plans. The proportion of Medicaid eligible children who saw a dentist at least once increased from 32 percent to 44 percent in the pilot program's first year. This model demonstrates how contracting with a single commercial entity that 1) has a strong existing dental network, 2) offers competitive market- based reimbursement and 3) streamlines administration to mirror the private sector can substantially improve access to care for Medicaid beneficiaries.

2) Tennessee's TennCare program was the first attempt by a state to move its entire Medicaid population into a statewide managed-care system. The impact on dental services was disastrous. The number of participating providers dwindled from its 1984 level of more than 1,700 to 386 general and specialist dentists available to treat the more than 600,000 TennCare eligible children. In 2002, the legislature enacted a statutory carve-out of dental services, which mandated a contract arrangement between the state and a private dental carrier to administer benefits for children (under age 21). The state retained control of reimbursement rates and increased them to market-based levels.

EXECUTIVE SUMMARY CONTINUED ON BACK

The new rate structure, in combination with administrative reforms, patient case management strategies and a requirement that the carrier maintain an adequate provider network, has substantially improved TennCare's provision of dental services. In just two years, the utilization rate among eligible beneficiaries has increased from 24 percent to 47 percent (Private sector utilization ranges from 50 percent to 60 percent). As of June 2004, about 700 dentists were participating in the program, with 86 percent of participants accepting new patients.

3) Alabama reformed its state-administered dental Medicaid program in 2000 to reimburse dentists at rates equivalent to those paid by commercial insurers. (The program still reimburses dentists at year 2000 rates.) The changes included creation of the Smile Alabama! initiative, which encompassed administrative reforms, a case management program, and increased outreach to both patients and dentists. The number of participating dentists has increased 47 percent, from 441 in 1999 to 674 in June 2004. The increased workforce resulted in increased utilization—26 percent of eligible children saw a dentist in 1999; in 2003 39 percent of eligible children had at least one dental visit.
4)

The Connecticut Health Foundation has been a leader in exploring contracting between federally qualified health centers (or similar public health clinics) and private practice dentists to provide care to underserved patients. Under these contracts, the health centers and dentists negotiate the types and amount of services to be provided. Dentists do not need to be Medicaid providers to treat Medicaid patients—the health centers are responsible for billing Medicaid for the services.

5) In Brattleboro, Vt., Head Start, the state health department, school officials and hospital administrators collaborated to establish a fee-for-service, for-profit dental center to address the needs of the underserved in a rural community. The practice serves both private paying and public assistance patients and pays a percentage of non-Medicaid revenues to the non-profit contracting entity (the community partners). In its first two years of operation, the clinic has cleared a huge backlog of children with acute and chronic dental needs and has begun to increase adult utilization as well.

The models in this white paper exemplify innovative ideas that could help other states and communities increase access to critically needed oral health services for their underserved populations. They were selected based on suggestions from state policymakers, public health representatives, state dental directors, the dental insurance industry and private-practice dentists. They reflect the consensus among these stakeholders that only through public-private collaborations will the nation make substantive progress in improving access to care for the underserved.

Ultimately, the success of these models will hinge on the quality of individual programs—financing, administrative processes and case management services, and their success in recruiting participating dentists. Their promise is that they are designed and implemented by the states or communities they will serve, allowing them to work toward meeting local needs according to local resources. Local and state dental societies stand ready to explore these collaborative models with community leaders for the improvement of the oral health of the American public.

Smile Alabama!

Alabama Medicaid's Dental Outreach Initiative

Bringing healthy smiles to all of Alabama's children is the goal of
Alabama Medicaid Agency's dental initiative, "Smile Alabama!"

Dentists Signing on With Medicaid Program

Since Governor Don Siegelman announced Alabama Medicaid Agency's dental initiative "Smile Alabama!" in October 2000, the agency has added more than 300 new dentists to its roster of professionals who treat the state's Medicaid children.

A major goal of the "Smile Alabama!" initiative is to increase the number of Medicaid dental providers. The first step to fulfilling this goal came when Medicaid's reimbursement rates for dental care were increased up to the average rates of the state's largest insurer, Blue Cross/Blue Shield.

In its effort to recruit new providers and retain currently enrolled dentists, the agency conducts one-on-one visits with dentists to further identify any problems and provide assistance with provider issues. Regional meetings are conducted to provide additional information about "Smile Alabama!" and explain Medicaid's Dental Program. Matching funds from public and private sources support the initiative grant from the Robert Wood Johnson Foundation's 21st Century Challenge Fund. Initiative partners include Alabama Power Foundation, Inc., Alabama Department of Public Health, West Alabama Health Services, and the University of Alabama at Birmingham.

Other Aspects of the Program

There are four components of the Dental Outreach Initiative.

1. Dental Reimbursement
2. Claims Processing
3. Patient Outreach
4. Provider Outreach

The Objectives of the Dental Outreach Initiative

- Provide adequate provider training and support, face-to-face
- Provide patient education on importance of prevention
- Provide training on the use of Targeted Case Management to address the no-show problems with Medicaid recipients
- Conduct provider recruitment visits
- Provide provider assistance with regularly scheduled follow-up calls
- Provide recipient education resources to providers
- Provide continued patient education resources/tools
- Assessment of success/failure to achieve program goals.

Making it work

Funding will be necessary to ensure the success of the Smile Alabama! Initiative. The governor committed $2 million in new state dollars to the Alabama Medicaid Dental Program in 2000 for a total of $6.5 million for dental rate increases. Medicaid continues to pursue additional funding sources to support the outreach component of the initiative.

Claims Processing Changes

- Increase the consistency of the Medicaid claim submission format with that of other payors
- Provide adequate training and continued technical support for claims submission
- Maintain an effective and efficient claims processing system
- Provide timely responses to provider inquiries and claims resolution

Dental Reimbursement

- Increase rates to 100% of BCBS 2000 rates *(Implemented in October 2000)*
- Implement an annual rate review and necessary adjustments

Provider Outreach

- Encourage and support appropriate utilization of dental services
- Increase the number of patients accessing appropriate dental services
- Increase the number of providers who accept Medicaid patients
- Increase the number of providers who participate in early education of Medicaid-eligible dental patients

Recipient Outreach

- Increase the number of Medicaid recipients who make and keep appointments
- Increase the number of Medicaid recipients who know what to expect when visiting a dental office and what is expected of them (Rights & Duties)
- Increase the number of Medicaid recipients who are compliant with the usual policies and procedures followed in a dental office
- Increase the number of Medicaid recipients who practice basic preventive

at-home dental care, with emphasis on the very young child

Dentists with any questions about the Alabama Medicaid Dental Program should call 334-242-5997 for additional information. Dental providers experiencing problems in resolving claims issues or with policy questions should also call this number.

The State of Alabama is committed to making our vision, “To insure every child in Alabama enjoys optimal health by providing equal and timely access to quality, comprehensive oral health care, where prevention is emphasized, promoting the total well being of the child” a reality.

# # #

Kathleen C. Schleif Roth D.D.S.

Curriculum Vitae 03.01.07

Address

Home Address	509 Summit Drive West Bend, WI. 53095
Phone	1 262 334 5249
Office Address	1713 Vogt Drive West Bend, WI. 53095
Phone	1 262 334 3070
Fax	1 262 334 1230
E-mail	rothk@ada.org

Birth date

06.22.50

Family Information

Marital Status	Married - 1972
Spouse	Daniel H. Roth D.D.S.
Children	Sara J. Isom age 31 married to Mr. Jeffrey Isom
	Andrew H. Roth age 29 married to Julie Roth
Grandchildren	Joseph R. Isom age 6
	Kathleen E. Isom age 3

Education

West Bend High School - graduate 1968

University of Wisconsin - Washington County
Associate Degree of Science - 1970

Marquette University School of Dentistry - Milwaukee, WI.
Doctor of Dental Surgery - 1974

Teaching Experience

Marquette Dental School Pre-Clinical part-time Crown and Bridge Faculty 1974-75,1976-77

Practice Type

General Dentistry 1974-present

Organized Dentistry Involvement

Local Component Level

President - Washington Ozaukee County Dental Society - 1990
Vice President - Washington Ozaukee County Dental Society -1989
Treasurer - Washington Ozaukee County Dental Society - 1988
Secretary - Washington Ozaukee County Dental Society – 1987

State Level

Past President – Wisconsin Dental Association 1999-2000
President - Wisconsin Dental Association 1998-99
President Elect - Wisconsin Dental Association 1997-98
Vice President - Wisconsin Dental Association 1996-97
Secretary - Wisconsin Dental Association - 1994-95
Wisconsin Dental Association Trustee - District 8 - 1992, 93, 94
Delegate to Wisconsin Dental Association House of Delegates - 1985,86, 87, 88, 89, 90, 91

National Level

American Dental Association President 2006-2007

Board of Directors-Give Kids A Smile Foundation 2007
ADA Foundation Board 2006-2007
ADA Business Enterprises Inc. 2006-2007
Committee on International Programs and Development 2006-2007
National HealthCare Information and Infrastructure 2006-2007
FDI Delegation to Dubai- 2007, delegation chair

American Dental Association President Elect 2005-2006

ADA Foundation Board 2005-2006
ADA Business Enterprises Inc. 2005-2006
Committee on International Programs and Development 2005-2006
FDI Delegation –delegate China 2006

American Dental Association 9th District Trustee 2001-2005

2001-2002 Board Committees
Strategic Planning
Information Technology
Diversity
ADA Awards Program

2002-2003 Board Committees
Strategic Planning
Information Technology
Diversity
Liaison to the Advisory Panel of the Minority Professional Leadership Institute
Liaison to the Council on Scientific Affairs
Appointment to the subcommittee on the New Evaluation Program for Professional Products
FDI Delegation – alternate to 2003 Congress in Sydney Australia

2003-2004 Board Committees
Information Technology
Diversity
Strategic Planning
Liaison to Council to Dental Education and Licensure
FDI Delegation - delegate to 2004 Congress, New Delhi, India
Presidential Taskforce on International Accreditation

2003-present JADA Review Committee

2004-2005- Board Committees
Information Technology – chair
Diversity – chair
Strategic Planning
Liaison to ADPAC
FDI Delegation – delegate to 2005 Congress, Montreal, Canada

American Dental Education Association 2001-present
Appointment to the Center for Education and Policy Research

American Dental Education Association 2003-2004

Think Tank creating Women's Health Interactive Network

Council member - American Dental Association
Council on Membership and Communications - 1993

Council member - American Dental Association –
Council on Membership - 1994, 95
Vice Chairman - Council on Membership - 1994

ADA Task Force on Alternate Pathways to Dental Hygiene Education 1999

Alternate Delegate to the American Dental Association House of Delegates
1989 - Hawaii
1990 - Boston
1991 - Orlando
1994 - New Orleans
1995 - Las Vegas
1996 – Orlando

Delegate to the American Dental Association House of Delegates
1993 - San Francisco
1997 - Washington D.C.
ADA Reference Committee Chairman to the Council of Communications and Membership 1997
1998 - San Francisco
1999 - Hawaii
2000 - Chicago
2001 - Kansas City

Professional Involvement

Chairman of the Workforce Study for Dentistry in Wisconsin 1998-2001

Chairman of the WDA-Milwaukee Brewer 5th Grade Smokeless Tobacco Education Program 1999 - present

Marquette
Marquette University School of Dentistry Dean's Advisory Council 1995-present
Marquette University School of Dentistry-Dean's Search Committee 1997
Marquette University School of Dentistry External Steering Committee 1998-present
Marquette University School of Dentistry Building Committee 1999-present
Sub-committees
Communications
Alumni Relations

Fundraising

Board of Directors – Vice Chairman – National Foundation of Dentistry for the Handicapped - Wisconsin Donated Dental Services Program 1998-present

Participant Mentorship Program 1996-present

Children's Health Alliance of Wisconsin June 1998 – January 2001

Steering Committee for the election of Dr. John Hinterman for ADA President 1993

Steering Committee for the election of Dr. S. Timothy Rose for ADA President 1997

Wisconsin Chairman for the election of Dr. George Bletsas for ADA President 2001

Lectures and Publications

Outcome of Statewide Workforce Analysis for Wisconsin 2000-2010
June 21, /2003 Goteborg, Sweden
ADEA 2nd International Women's Leadership Conference

Congressional briefing on "Women's Oral Health: Implications Across the Lifespan" panel participant June 5, 2003, Washington D. C.

"Women's Oral Health Throughout Phases of a Lifespan "Women in Dentistry Worldwide- FDI World Dental Congress September 12, 2004 New Delhi, India

Women in Leadership- moderator – August 29, 2005 Montreal, Canada
ADEA 3rd International Women's Leadership Conference

Honorary Societies

Pierre Fauchard Academy member - 1994
International College of Dentists - 1995
American College of Dentists-1999
American Association of Women Dentists – 2000
Omicron Kappa Upsilon
Xi Chapter at Marquette University School of Dentistry 2006

Community Involvement

1st grade religious education instructor Holy Angels 1981- 1987
Washington Ozaukee County Children's Dental Health Month coordinator 1986-1990
University of Wisconsin Washington County - University Council 1983 - 1991
Chamber of Commerce member 1993-present
University of Wisconsin Washington County - Foundation member 1994- present
Commencement speaker - University of Wisconsin Washington County May 1994
West Bend Chamber of Commerce Dental Liaison 1997-98 Community Emergency Preparedness Training Team October 2004

Awards/Honors

University of Wisconsin Washington County Alumni of the Year 1994
Wisconsin Dental Association "Pyramids of Pride" Award- Donated Dental Services Program 2002
Wisconsin Dental Association "Pyramids of Pride" Award – 5th Grade Statewide Spit Tobacco Education Program- ADA Golden Apple Award - 2003
Marquette University "Dental Community Service Award" April 2005
WDA Pyramids of Pride Special Recognition Award November 2005